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Health Care Financing Program Statistics

Medicare: Use of Home Health Services, 1976

Published by Health Care Financing Administration

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Health Care Financing Medicare Program Statistics

Medicare Program Statistics are published periodically by the Health Care Financing Administration's Office of Research, Demonstrations, and Statistics.

The Health Care Financing Administration was established in March 1977 to combine HEW's health financing and quality assurance programs into a single agency. HCFA is responsible for the operation of the Medicare and Medicaid programs, the Professional Standards Review Organization (PRSO) program, Federal survey and certification efforts, and a variety of health care quality assurance activities.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 45 million aged, disabled, and poor Americans. HCFA is committed to making beneficiaries aware of the services for which they are eligible, promoting the accessibility of those services and ensuring that HCFA policies and actions promote efficiency and quality within the total health care delivery system.

HCFA's Office of Research, Demonstrations, and Statistics (ORDS) conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. ORDS also assesses the impact of HCFA programs on health care costs, program expenditures, beneficiary access to services, health care providers, and the health care industry. In addition, ORDS monitors national health care expenditures and prices and provides actuarial analyses on the costs of current HCFA programs as well as the impact of possible legislative or administrative changes in the programs.

Medicare Program Statistics present detailed reports on Medicare enrollment, providers, and the use of reimbursement for covered services. Medicare enrollment data report the number of persons insured under Part A and Part B of the Medicare program by age, race, sex, and place of residence. Provider statistics consist of information on the number, distribution, and characteristics of hospitals, skilled nursing facilities, home health agencies, and independent laboratories certified to furnish and receive payment for covered health services to Medicare beneficiaries.

Medicare—Use of Home Health Services: 1976

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Health Care Financing Administration
Office of Research, Demonstrations,
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Medicare—Use of Home Health Services: 1976

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Introduction

Purpose

This report presents 1976 data on the use of home health agency services by aged and disabled recipients of Medicare benefits. Time trends are presented for selected measures to highlight significant changes which have occurred in home health care use during the 1969-1976 period.

Program Background

The Medicare Program was enacted on July 30, 1965, as Title XVIII of the Social Security Act, and it became effective on July 1, 1966. The program offers two separate but coordinated insurance coverages—Hospital Insurance (HI), also referred to as Part A, and Supplementary Medical Insurance (SMI), referred to as Part B—both of which provide reimbursement for Home Health Agency (HHA) services. Home health visits within a calendar year, and no prior stay structure so that needed health care services could be provided at an appropriate level. This was intended to reduce unnecessary use of more costly inpatient hospital and/or skilled nursing facility services.

To qualify for reimbursement for HHA services, a beneficiary must be under the care of a physician, confined to a home, and in need of intermittent skilled nursing care or physical or speech therapy. In addition to skilled nursing and physical and speech therapy, reimbursable services include occupational therapy, medical social services, and home health aide services, as well as medical supplies other than drugs or biologicals and medical appliances. A physician is required to determine the need for home health services and to establish a patient care plan for services. The HHA providing services must be certified for participation in Medicare.

Coverage under the HI part of the program provides for reimbursement of the reasonable cost of up to 100 home health visits during a benefit period.[1] These visits must occur in the year following a beneficiary's most recent discharge from a hospital stay of at least three consecutive days. A plan of treatment must be established by the patient's physician within 14 days of discharge from the hospital or skilled nursing facility, and the services must be necessary for further treatment of the condition for which the patient received hospital or skilled nursing facility services.

Coverage under SMI places a limit of 100 home health visits within a calendar year and no prior stay in a hospital or a skilled nursing facility is required; otherwise, the requirements for coverage are the same as those under HI. Also, SMI may be used to cover home health visits required after benefits under HI have been exhausted.

The Social Security Amendments of 1972[2] provided incentives to increase the use of home health services and to reduce the use of inpatient hospital and skilled nursing facility services. The Amendments also included provisions to reduce administrative problems relative to the determination of coverage and payment for HHA services. The key elements of the 1972 Amendments affecting the use of HHA services and the amounts reimbursed for them were:

- Elimination of the 20 percent coinsurance for SMI coverage of home health services furnished on or after January 1, 1973;
- Authorization for the Secretary of HEW to establish, by diagnosis, periods of coverage for home health care under the hospital insurance part of Medicare for individuals with specified conditions;
- Allowance of payments for services that neither the home health agency nor the beneficiary knew or could reasonably have been expected to know were not covered;
- Extension of Medicare coverage (including HHA services) to persons receiving social security benefits based on disability or end-stage renal disease (This coverage began in July 1973.)

These provisions resulted in an increase in the use of HHA services and the amounts reimbursed by Medicare for them.

Major Findings

The following items present the major findings of this report.

Reimbursement Trends, 1969-1976

In 1969, Medicare reimbursement for home health services was $78 million and constituted 1.2 percent of all Medicare reimbursements.

Policy guidelines issued in 1969 defined more precisely the circumstances under which home health services would be covered; their effect was to reduce the amounts reimbursed for home health services. A low point was reached in 1971 when reimbursements for home health services constituted only about three-fourths of one percent of all Medicare reimbursements.

The Social Security Amendments of 1972 simplified administrative problems relating to payment for home health services, removed the coinsurance provisions, and extended Medicare coverage to disabled persons and to persons with end-stage renal disease. The result was an acceleration in the use of home health services to the point that, by 1976, reimbursements were $290 million, or 1.6 percent of all Medicare reimbursements.

Utilization and Charges, 1974-76

Fifty percent more people received home health visits in 1976 than in 1974; visits increased by 65 percent and, on the average, persons served in 1976 received 10 percent more visits than persons served in 1974.

Between 1974 and 1976, total charges for home health services increased 112 percent, and the average charges incurred by persons using HHA services increased from $376 to $531 a year.

Because HHA payments increased at a greater rate than total Medicare payments, they increased from 1.2 percent of total Medicare payments in 1974 to 1.6 percent in 1976.

Utilization and Charges by Demographic Characteristics, 1976

An estimated 589,000 persons received reimbursable HHA services in 1976, a rate of 22.9 persons served per 1,000 enrolled; they incurred total charges

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[1] A benefit period begins with the first day a patient receives inpatient hospital or skilled nursing services and ends after 60 consecutive days in which the patient was an inpatient of neither a hospital nor a skilled nursing facility. There is no limit to the number of benefit periods to which a patient is entitled.

[2] Title XVIII of the Social Security Act as amended by P.L. 92-603, October 30, 1972.

of $312.3 million, an average of $531 per person served.

Medicare reimbursement amounted to $289.9 million, an average of $492 per person served.

Ninety-three percent of the total charges recorded were reimbursed.[3]

Sixty-two percent of the persons served received services under HI only, 27 percent received services under SMI only, and the remaining 11 percent received services under both programs.

Fifty-seven percent of the persons served were age 75 and over; 64 percent were female; 90 percent were white; 93 percent had a Medicare status of aged, and the remainder had a status of disabled or end-stage renal disease only.

Regionally, the number of persons served per 1,000 enrollees ranged from 32.2 in the Northwest to 17.4 in the North Central States; the average number of visits per person served was 26.3 in the South as compared to 21 in the other regions; charges per person served in the South averaged $605, as compared to less than $500 in the other regions.

By State, the number of persons served per 1,000 enrolled ranged from 62.4 in Vermont to 4.5 in North Dakota; the average number of visits per person served exceeded 38 in Mississippi, Louisiana, and Nevada in contrast to 13.3 per person in Arkansas; charges per person served in Louisiana and Mississippi averaged $992, as compared to $155 in South Dakota.

Number and Types of Services

Over 13.3 million visits were provided, a mean of 22.7 and a median of 11.6 visits for each person served; 75 percent of the persons served received 27.5 or fewer visits; 90 percent of the persons served received 56.0 or fewer visits.

Fifty-nine percent of the visits were for nursing services, 28 percent for home health aide services, and 10 percent for physical therapy services.

Types and Distribution of Home Health Agencies, 1976

Between 1975 and 1976, use of private non-profit agencies increased by over 100 percent for number of persons served and visit charges and by 98.4 percent for number of visits.

Visiting nurse associations provided 4.9 million visits to 245,000 Medicare recipients.

Proprietary and private non-profit agencies provided 30 percent of total visits to 22 percent of all persons served, accounting for 35 percent of total charges.

Visiting nurse associations comprise two-thirds of all HHAs in New England; 78 percent of all HHAs in the East South Central States are administered by State and local governments; 64 percent of all private nonprofit agencies are in the South.

Organization of Report

The remainder of this report is organized into three chapters followed by three appendices. Chapter II presents data on the patterns of utilization, charges, and reimbursements for home health services used by Medicare beneficiaries. Reimbursement trends since 1969 are analyzed. Chapter III describes the types of home health agencies which qualify for Medicare reimbursement and analyzes the distribution of services by type of agencies and geographic location. Chapter IV presents conclusions derived from preceding analyses. The concluding chapter summarizes the rapid growth between 1974 and 1976 in the volume of HHA services furnished to Medicare beneficiaries. The decrease in the proportion of nursing visits and the increase of home health aide services among the services furnished are also examined.

Utilization Statistics

This Chapter presents data regarding trends in reimbursement patterns, the number of persons served and services provided, patient distribution, patients' demographic characteristics, categories of services provided, and type of Medicare coverage utilized.

Reimbursement Trends, 1969-1976

Table 1 shows that, although *total* Medicare reimbursements increased each year from 1969-1974, the number of home health visits and the amounts reimbursed for such services decreased in 1970 and 1971. A low point was reached in 1971 when reimbursements for home health services represented only three-fourths of one percent of total Medicare payments. This decrease resulted from new Social Security Administration policy guidelines which more precisely defined what conditions were reimbursable.

Reimbursements for home health services increased significantly during 1972 and each subsequent year. This increased use was stimulated by the 1972 Amendments which expanded payments and coverage of home health care and extended coverage to the disabled and those who suffer from end-stage renal disease. By 1974, home health service Medicare reimbursements had returned to thier 1969 levels.

Wage and price controls were instituted in 1971 under the Economic Stabilization Programs and remained in effect for the health care industry until April 1974. These controls may have influenced HHA reimbursement and, therefore, use during this period, but this cannot be determined from the data.

Between 1975 and 1976, reimbursements for home health services increased over 34 percent, as compared with an overall increase of 20 percent in total Medicare reimbursement during the same period. In 1976, HHA payments continued to increase at a greater rate than total Medicare payments, amounting to 1.6 percent of total Medicare payments.

Persons Served, Services, and Charges, 1976

Table 2 shows that, during 1976, approximately 589,000 persons (22.9 per 1,000 enrolled) received home health services which were covered by Medicare. This is a 50 percent increase over the 393,000 persons who received services in 1974 (16.5 per 1,000 enrolled).

The total number of HHA visits provided increased 65 percent from 8.1 million in 1974 to 13.3 million in 1976. Total charges amounted to $312 million in 1976,

[3] Reimbursement is calculated on a cost basis that is agreed upon by the home health agency and intermediary. The intermediary determines the appropriate percentage of charges to be paid, not to exceed 100 percent.

an increase of 112 percent over the charges recorded for 1974. On the averages, persons served in 1976 received 10 percent more visits and were charged 41 percent more than in 1974. Total charges shown include those for the durable medical equipment and supplies, excluding drugs and biologicals, furnished by home health agencies in addition to the charges for medical personnel on a per-visit basis.

Use of HHA services increased in all geographic regions, but the greatest increase occurred in the South where the number of persons served increased by 68 percent, and the number of visits and charges increased 87 percent and 144 percent, respectively, over the three-year period. During 1976, over one-third of the persons served resided in the Northeast. However, beneficiaries in the South received the greatest number of visits and had the largest number of visits and highest charges per person served. On an individual basis, much greater use was recorded for beneficiaries residing in areas outside the United States, but they accounted for less than 2 percent of all visits and charges.

Table 1
Medicare Reimbursement, Reimbursement for Home Health Services, and Number of Home Health Visits Under Medicare, Calendar Years 1969-76

(In millions)

	Total Medicare Reimbursement		Home Health Agency Reimbursement			Home Health Visits	
Year	Amount	Percent Change	Amount	Percent Change	As Percent of Total Medicare Reimbursement	Number	Percent Change
1969	$ 6,276	---	$ 78	---	1.24	8.5	---
1970	6,748	7.5	62	-21.2	.91	6.0	-29.9
1971	7,459	10.5	57	- 7.7	.76	4.8	-20.5
1972	8,174	9.6	66	16.1	.81	5.2	9.2
1973	9,562	17.0	93	40.8	.97	6.4	22.3
1974	11,847	23.9	144	54.7	1.21	8.2	28.7
1975	14,652	23.7	216	50.1	1.47	10.8	32.0
1976	17,637	20.4	290	34.3	1.64	13.3	23.1

Source: Health Care Financing Administration, unpublished utilization statistics. Amounts are for year in which expenses were incurred, based on bills processed through December 1977. Thus, data for most recent years are less complete than data for earlier years.

Table 2
Number of Persons Served, Number of Visits, and Amount of Charges, by Region, 1974-76
(Numbers and Amounts in thousands)

Geographic Area and Year		Persons Served		Visits		Visit Charges		Total Charges [1]	
		Number	Per 1,000 Enrollees	Number	Per Person Served	Amount	Per Visit	Amount	Per Person Served
Total, All Areas	1974	392.7	16.5	8,070	20.6	$137,406	$17	$147,499	$376
	1975	499.6	20.2	10,805	21.6	211,994	20	227,001	454
	1976	588.7	22.9	13,335	22.7	292,697	22	312,325	531
Northeast	1974	143.8	24.4	2,899	20.2	47,166	16	50,376	350
	1975	175.9	29.2	3,655	20.8	67,848	19	71,259	405
	1976	198.1	32.2	4,201	21.2	85,617	20	89,853	454
North Central	1974	82.8	12.7	1,527	18.4	25,082	16	25,486	308
	1975	101.5	15.2	1,958	19.3	36,012	18	37,315	368
	1976	118.6	17.4	2,446	20.6	52,498	21	54,195	457
South	1974	102.3	13.6	2,417	23.6	42,332	18	47,274	462
	1975	139.0	17.7	3,519	25.3	72,831	21	81,060	583
	1976	171.7	21.2	4,519	26.3	104,877	23	115,434	672
West	1974	60.2	15.9	1,087	18.1	20,199	19	21,425	356
	1975	78.4	19.9	1,495	19.1	31,523	21	32,908	420
	1976	93.1	22.8	1,916	20.6	44,756	23	46,732	502
Other Areas [2]	1974	3.7	14.4	140	38.3	2,627	19	2,938	803
	1975	4.9	18.1	177	36.0	3,732	21	4,459	905
	1976	7.3	14.9	252	34.7	4,948	20	6,111	842

[1] Includes charges for durable medical equipment and supplies in addition to visit charges.
[2] Includes Puerto Rico, Virgin Islands, Guam, other outlying areas, and residence unknown.

Distribution of Persons Served, 1976

Table 3 indicates that, nationally, during 1976, 22.9 of every 1,000 Medicare enrollees received home health benefits, with the ratio ranging from 40.5 per 1,000 in New England to 15.2 per 1,000 in the West North Central States. Beneficiaries in the West South Central States received more visits per person served (29.7) and had the highest average charge per person served ($794), both considerably above the national average.

Among the individual States, the number of persons served per 1,000 enrollees ranged from 62.4 in Vermont to 4.5 in North Dakota. Beneficiaries receiving HHA services in Louisiana and Mississippi averaged over 38 visits and were charged $992. Beneficiaries residing in Nevada who used HHA services also received an average of 38 visits, but were charged considerably less on the average, $665. Arkansas showed only 13.3 HHA visits per person served, while in South Dakota, average charges incurred per user were only $155.

Table 4 shows the distribution of persons receiving home health services by number of visits and type of coverage under Medicare in 1976. Approximately 18,700 persons, 3 percent of those served, received 100 or more visits in 1976. Forty-two percent received 10 or fewer visits while 12 percent received 50 visits or more.

Table 3
Number of Persons Served, Number of Visits, and Amount of Charges, by Geographic Area, 1976
(Numbers and Amounts in thousands)

Geographic Area	Persons Served		Visits		Visit Charges		Total Charges		Total Reimbursement	
	No.	Per 1,000 Beneficiaries	No.	Per Person Served	Amount	Per Visit	Amount	Per Person Served	Amount	Per Person Served
Total, all areas	588.7	22.9	13,335	22.7	$292,697	$22	$312,325	$531	$289,851	$492
United States	581.4	23.1	13,083	22.5	287,749	22	306,214	527	283,952	488
Northeast	198.1	32.2	4,201	21.2	85,617	20	89,853	454	84,938	429
North Central	118.6	17.4	2,446	20.6	52,498	21	54,195	457	50,579	427
South	171.7	21.2	4,519	26.3	104,877	23	115,434	672	103,794	605
West	93.1	22.8	1,916	20.6	44,756	23	46,732	502	44,640	479
Northeast										
New England	61.4	40.5	1,389	22.6	22,909	16	23,371	381	22,455	366
Middle Atlantic	136.7	29.5	2,812	20.6	62,709	22	66,482	486	62,483	457
North Central										
East North Central	84.6	18.5	1,638	19.4	37,433	23	38,348	453	36,46	431
West North Central	34.0	15.2	808	23.8	15,066	19	15,846	467	14,116	416
South										
South Atlantic	93.8	23.2	2,300	24.5	55,291	24	58,247	621	54,729	583
East South Central	37.8	22.5	1,031	27.3	22,625	22	25,892	671	22,050	583
West South Central	40.0	16.8	1,188	29.7	26,961	23	31,795	794	27,015	675
West										
Mountain	20.9	21.6	482	23.1	8,613	18	9,187	440	8,619	413
Pacific	72.2	23.2	1,434	19.9	36,143	25	37,545	520	36,021	499
New England										
Maine	5.9	40.4	123	20.9	2,263	18	2,303	391	2,205	375
New Hampshire	4.3	42.7	90	20.8	1,066	12	1,070	248	1,026	238
Vermont	3.7	62.4	90	24.3	1,304	14	1,311	352	1,268	340
Massachusetts	28.0	38.5	641	22.9	10,511	16	10,763	384	10,289	367
Rhode Island	5.2	41.1	114	21.9	1,978	17	2,040	391	2,028	389
Connecticut	14.2	40.1	331	23.3	5,786	17	5,885	414	5,638	397
Middle Atlantic										
New York	52.3	23.3	1,063	20.3	27,684	26	29,680	568	27,438	525
New Jersey	26.8	31.4	657	24.5	13,284	20	13,822	515	13,662	509
Pennsylvania	57.6	37.5	1,092	19.0	21,741	20	22,981	399	21,384	371
East North Central										
Ohio	27.2	22.7	507	18.6	10,534	21	10,813	397	10,311	378
Indiana	5.7	9.6	110	19.2	1,788	16	1,931	339	1,841	323
Illinois	22.1	17.4	526	23.8	14,060	27	14,320	648	13,434	608
Michigan	17.7	18.8	259	14.7	6,846	26	6,907	391	6,659	377
Wisconsin	11.9	21.0	235	19.8	4,205	18	4,377	367	4,218	354

Table 3—Continued
Number of Persons Served, Number of Visits, and Amount of Charges, by Geographic Area, 1976
(Numbers and Amounts in thousands)

Geographic Area	Persons Served		Visits		Visit Charges		Total Charges		Total Reimbursement	
	No.	Per 1,000 Beneficiaries	No.	Per Person Served	Amount	Per Visit	Amount	Per Person Served	Amount	Per Person Served
West North Central										
Minnesota	5.9	12.3	136	23.3	2,494	18	2,595	442	2,542	433
Iowa	3.8	9.5	81	21.6	915	11	937	249	904	240
Missouri	17.5	26.4	462	26.3	9,616	21	10,166	579	8,678	495
North Dakota	.4	4.5	7	19.9	81	11	92	253	87	237
South Dakota	.6	6.6	12	18.9	92	8	96	155	90	146
Nebraska	3.0	14.2	55	18.4	968	18	1,035	350	1,006	340
Kansas	2.8	9.2	55	19.4	900	16	924	327	809	286
South Atlantic										
Delaware	1.9	32.2	46	24.9	666	14	681	365	642	344
Maryland	9.4	25.1	177	18.9	4,048	23	4,118	438	4,000	425
District of Columbia	2.5	32.6	52	20.9	1,428	27	1,441	576	1,268	507
Virginia	5.7	11.6	120	21.1	2,654	22	2,669	469	2,608	458
West Virginia	4.1	15.8	79	19.4	1,553	20	1,691	415	1,498	367
North Carolina	10.6	18.2	256	24.1	4,860	19	5,188	488	5,030	474
South Carolina	6.9	24.7	107	15.5	2,387	22	2,835	410	2,676	387
Georgia	5.7	11.2	100	17.5	2,430	24	2,656	467	2,473	435
Florida	47.1	33.2	1,362	28.9	35,264	26	36,968	786	34,536	734
East South Central										
Kentucky	7.3	17.0	135	18.5	2,925	22	3,289	451	3,096	425
Tennessee	11.1	21.5	265	23.9	5,242	20	5,977	539	5,393	487
Alabama	10.0	22.7	265	26.6	6,263	24	6,708	673	6,158	618
Mississippi	9.5	31.9	367	38.6	8,195	22	9,419	992	7,404	780
West South Central										
Arkansas	2.2	7.0	29	13.3	686	24	734	335	701	320
Louisiana	10.5	26.0	403	38.4	9,254	23	10,405	992	8,111	773
Oklahoma	2.8	7.5	39	13.7	912	24	947	338	827	295
Texas	24.5	19.0	718	29.3	16,109	22	19,708	803	17,377	708
Mountain										
Montana	1.4	16.0	34	24.9	475	14	483	357	434	318
Idaho	2.4	26.4	59	24.9	923	16	1,083	454	1,062	446
Wyoming	.7	18.7	20	28.3	373	19	381	546	311	446
Colorado	6.1	25.8	114	18.7	2,523	22	2,545	416	2,413	395
New Mexico	3.3	30.6	98	29.6	1,409	14	1,462	442	1,398	423
Arizona	4.9	19.4	100	20.2	2,055	21	2,312	469	2,125	431
Utah	1.4	13.8	30	21.6	403	13	453	323	437	311
Nevada	.7	13.1	27	38.4	452	17	462	665	439	632
Pacific										
Washington	8.9	21.7	148	16.6	3,601	24	3,733	419	3,487	391
Oregon	6.2	21.3	117	18.7	3,001	26	3,253	522	3,108	499
California	55.5	23.8	1,146	20.7	29,078	25	30,002	540	28,921	521
Alaska	.1	9.0	1	10.0	26	29	26	296	25	287
Hawaii	1.5	22.0	22	15.1	437	20	531	364	481	330
Other areas[1]	7.3	14.9	252	34.7	4,948	20	6,111	842	5,899	813

[1] Includes Puerto Rico, Virgin Islands, Guam, other outlying areas and residence unknown.

Table 4
Number and Percentage Distribution of Persons, Number of Visits, and Type of Coverage, 1976
(In thousands)

Number of Visits	Total		Hospital Insurance Only		Supplementary Medical Insurance Only		Hospital and Medical Insurance	
	Persons Served	Percent	Persons Served	Percent	Persons Served	Percent	Percent Served	Percent
Total	588.7	100.0	367.2	100.0	157.8	100.0	63.7	100.0
1-4	133.3	22.6	85.8	23.4	46.3	29.3	1.2	1.9
5-9	116.4	19.8	80.1	21.8	31.8	20.2	4.6	7.2
10-19	131.3	22.3	85.2	23.2	34.6	21.9	11.5	18.1
20-29	68.2	11.6	43.0	11.7	16.4	10.4	8.8	13.8
30-39	39.3	6.7	24.9	6.8	8.3	5.3	6.2	9.7
40-49	26.9	4.6	16.0	4.4	5.7	3.6	5.2	8.2
50-99	54.4	9.2	29.3	8.0	12.0	7.6	13.1	20.6
100 or more	18.7	3.2	2.9	.8	2.6	1.6	13.2	20.8

Variations in Use by Demographic Characteristics, 1976

Table 5 shows differences in the use of HHA services by demographic characteristics. Medicare enrollees age 75 and over comprised 36 percent of all enrollees, but constituted 57 percent of the persons served and HHA services used. Females used a greater proportion of HHA services than males; 375,000, two-thirds of the 589,000 persons served in 1976, were female, although only about 57 percent of the enrolled Medicare population in 1976 was female. The use of HHA services by women beyond their proportion of the enrollment may reflect the effect of age, since women have a higher average age than men.

This report groups the 1976 beneficiaries of home health services by "white" and "all other races." Whites outnumbered all other races by 9 to 1 in the use of home health services in 1976, about the same race ratio enrolled in the Medicare program. Therefore, services appear to be equitably distributed by race.

Use by Type of Service

Nursing care is the primary service provided by HHAs under Medicare. Table 6 indicates that in 1976 approximately 565,000 beneficiaries, 96 percent of those served, received nursing care. Home health aide services ranked second with 180,000 persons served, while physical therapy services were provided to one patient in five. Over 13.3 million visits were recorded for 1976; of these, about 7.9 million, or 59 percent, were for nursing care. An additional 3.8 million visits, or 28 percent, were recorded for home health aide services. When home health aide services were used, they tended to be used intensively, almost 21 visits per person served.

Table 7 which integrates the data from this report and previous reports on home health services,[4] shows that the distribution of services by type of visits has been changing since 1974. Although the number of nursing visits increased between 1974 and 1976, it decreased as a percentage of total visits from 65 percent to 59 percent. During the same period, home health aide visits increased from 23 percent to 28 percent of all visits. The distribution of charges moved in tandem with the distribution of visits. During the 1974-76 period, charges for nursing visits decreased from about 66 percent of all visit charges to 61 percent while, at the same time, the charges for home health aide visits increased from about 21 percent of all visit charges to almost 25 percent. During this period, persons using home health aide services, as a percent of all persons served, increased from 24 percent in 1974 [5] to 31 percent in 1976.

This shift in the distribution of services and charges and persons using home health aide services may be due to the change in the mix of home health agencies certified under the program. This is discussed in Chapter III, Utilization by Type of Agency.

Use by Type of Medicare Coverage

Approximately 11 percent of the persons served received home health services under both HI and SMI, averaging more than 57 visits per person. More than 62 percent of the persons served, however, received benefits solely under the HI program. The number of persons served by type of coverage is shown in the following table.

Type of Coverage	Persons Served	
	Percentage Distribution	Average Number of Visits
Total	100.0	22.7
HI and SMI	10.8	57.2
HI only	62.4	18.7
SMI only	26.8	17.9

[4] Wayne Callahan, *Medicare: Utilization of Home Health Services, 1974;* HI-79; Office of Research and Statistics, Social Security Administration; Nov. 2, 1977, and *Medicare: Utilization of Home Health Services, 1975,* RS-2, Office of Research, Demonstrations, and Statistics; Health Care Financing Administration.

[5] Ibid.

Table 5
Number and Percentage Distribution of Persons Served, Visits, and Amount of Charges by Selected Demographic Characteristics, 1976
(Numbers and Amounts in thousands)

Demographic Characteristics	Enrollees	Persons Served		Visits	Visit Charges	Total Charges	Total Reimbursement
		Number	Per 1,000 Enrollees				
Total	25,663	588.7	22.9	13,335	$292,697	$312,325	$289,851
Age							
Under 65	2,392	42.7	17.8	1,087	23,904	25,721	23,882
65-66	3,284	31.8	9.7	686	15,526	16,611	15,424
67-68	3,123	38.5	12.3	846	18,957	20,300	18,904
69-70	2,819	42.6	15.1	953	21,534	22,951	21,377
71-72	2,538	46.8	18.5	1,050	23,603	25,020	23,269
73-74	2,251	48.6	21.6	1,096	24,345	25,984	24,144
75-79	4,381	127.3	29.1	2,869	63,293	67,258	62,426
80-84	2,906	115.3	39.7	2,567	55,407	58,948	54,753
85 and over	1,969	95.0	48.2	2,183	46,128	49,531	45,672
Sex							
Male	10,946	213.8	19.5	4,717	104,869	113,621	105,353
Female	14,727	374.9	25.5	8,618	187,828	198,703	184,498
Race:							
White	22,625	528.0	23.3	11,883	258,269	275,261	256,094
All other races	3,038	60.7	20.0	1,452	34,428	37,063	33,758
Medicare Status							
Aged	23,271	546.0	23.5	12,248	268,793	286,604	265,969
Disabled	2,392	42.7	17.8	1,087	23,904	25,721	23,882
		Percentage Distribution					
Total	100.0	100.0		100.0	100.0	100.0	100.0
Age							
Under 65	9.3	7.3		8.2	8.2	8.2	8.2
65-66	12.8	5.4		5.1	5.3	5.3	5.3
67-68	12.2	6.5		6.3	6.5	6.5	6.5
69-70	11.0	7.2		7.1	7.4	7.3	7.4
71-72	9.9	7.9		7.9	8.1	8.0	8.0
73-74	8.8	8.3		8.2	8.3	8.3	8.3
75-79	17.1	21.6		21.5	21.6	21.5	21.5
80-84	11.3	19.6		19.3	18.9	18.9	18.9
85 and over	7.7	16.1		16.4	15.8	15.9	15.8
Sex							
Male	42.7	36.3		35.4	35.8	36.4	36.3
Female	57.4	63.7		64.6	64.2	63.6	63.7
Race:							
White	88.2	89.7		89.1	88.2	88.1	88.4
All other races	11.8	10.3		10.9	11.8	11.9	11.6
Medicare Status							
Aged	90.7	92.7		91.8	91.8	91.8	91.8
Disabled	9.3	7.3		8.2	8.2	8.2	8.2

Table 6

Number of Persons Served, Number of Visits, and Amount of Charges, by Type of Visit and Type of Agency, 1976

Utilization and Type of Visit	All Agencies	Visiting Nurse Association	Combined Government and Voluntary	Government	Hospital Based	Proprietary	Private Nonprofit	Other[1]
Persons Served[2]								
Total (in thousands)	588.7	245.8	18.7	124.0	63.3	24.5	103.6	8.8
Nursing care	564.5	238.4	18.2	119.2	60.6	22.9	97.0	8.3
Home Health aide	180.2	65.0	4.0	31.6	14.6	13.0	50.2	1.7
Physical therapy	126.0	47.5	2.9	20.7	17.5	5.8	29.9	1.8
Other[3]	67.0	23.4	0.9	6.7	10.8	5.3	19.1	0.9
Visits								
Total (in thousands)	13,335	4,901	317	2,556	1,318	724	3,285	233
Nursing care	7,878	3,073	204	1,585	811	322	1,721	162
Home health aide	3,771	1,278	77	710	272	296	1,101	37
Physical therapy	1,281	415	26	208	175	80	353	24
Other	405	135	9	53	61	26	111	10
Visit Charges								
Total (in thousands)	$292,697	$93,925	$7,140	$47,500	$35,229	$18,461	$85,376	$5,066
Nursing care	177,820	61,259	5,146	31,986	21,291	8,797	45,771	3,570
Home health aide	72,127	20,885	1,220	10,304	7,125	6,516	25,462	615
Physical therapy	31,708	8,422	578	4,098	4,947	2,349	10,691	623
Other	11,042	3,359	197	1,112	1,865	800	3,452	258
Average Number of Visits Per Persons Served								
Total	22.7	19.9	16.9	20.6	20.8	29.6	31.7	26.4
Nursing care	14.0	12.9	11.3	13.3	13.4	14.1	17.7	19.6
Home health aide	20.9	19.7	19.3	22.4	18.6	22.7	21.9	21.7
Physical therapy	10.2	8.7	8.9	10.1	10.0	13.8	11.8	13.7
Other	6.0	5.8	10.9	7.9	5.7	4.3	5.8	11.0
Average Visit Charges Per Person Served								
Total	$497	$382	$381	$383	$556	$754	$824	$574
Nursing care	315	257	284	268	351	384	472	432
Home health aide	400	321	306	326	487	500	508	359
Physical therapy	252	177	199	198	283	405	358	355
Other	165	144	230	166	173	150	181	275
Average Charge Per Visit								
Total	$22	$19	$23	$19	$27	$26	$26	$22
Nursing care	23	20	25	20	26	27	27	22
Home health aide	19	16	16	15	26	22	23	17
Physical therapy	25	20	22	20	28	29	30	26
Other	27	25	21	21	31	31	31	25

[1] Includes rehabilitation and skilled nursing facility-based agencies.
[2] Detail does not add to total since persons may receive more than one type of service.
[3] Includes speech or occupational therapy, medical social services and other health disciplines.

Table 7
Number of Visits and Amount of Charges by Type of Visit, 1974-1976

	Visits					Visit Charges				
	Total	Nursing Care	Home Health Aide	Pyysical Therapy	Other[1]	Total	Nursing Care	Home Health Care	Physical Therapy	Other[1]
1974	8,070	5,217	1,888	784	181	$137,406	$ 89,989	$28,187	$15,439	$ 3,790
1975	10,805	6,647	2,840	1,037	281	211,944	133,200	48,230	23,530	6,984
1976	13,335	7,878	3,771	1,281	405	292,697	177,820	72,127	31,708	11,042
	Percentage Distribution									
1974	100.0	64.6	23.4	9.7	2.2	100.0	65.5	20.5	11.2	2.8
1975	100.0	61.5	26.3	9.6	2.6	100.0	62.8	22.8	11.1	3.3
1976	100.0	59.1	28.3	9.6	3.0	100.0	60.8	24.6	10.8	3.7

[1] Includes speech or occupational therapy, medical social services, and other health disciplines.

If a person is eligible for services under HI and SMI, the services are charged under HI. However, if the 100 visits allowed in a benefit period under HI are exhausted, benefits under SMI may be used. Approximately 2,600 beneficiaries using HHA services, or 0.4 percent of those served, exhausted the 100 visits allowed under SMI.

Use By Type of Agency

This Chapter presents data on the types of home health agencies, the growth of private non-profit agencies, and the distribution of services by agency type.

Types of Home Health Agencies

Home health agencies certified to provide services to Medicare beneficiaries include public, proprietary, and private non-profit agencies such as visiting nurse associations, subdivisions of State or local health departments, combinations of visiting nurse associations and local health departments, and home health care divisions of hospitals or other health care institutions primarily engaged in providing skilled nursing and other therapeutic services in the home. Private organizations which do not qualify as non-profit groups, exempt from Federal income taxation under Section 501 of the Internal Revenue Code of 1954, must be licensed under State law to be considered for certification as home health agencies under Medicare.

Private Non-Profit Agencies

Private non-profit agencies showed the largest relative and absolute increases in use between 1975 and 1976. This is partly due to the increase in the number of these agencies which were certified for participation in Medicare during this period—from 225 in 1975 to 298 in 1976.

Data were not tabulated separately for private non-profit agencies in 1974, but the increase in the number of persons served by these agencies and the visit charges exceeded 100 percent between 1975 and 1976, while the number of visits made by these agencies increased 98.4 percent. During 1976, bills were submitted for reimbursement by 277 private nonprofit agencies. There were no significant changes in the number of other certified agencies during the same period.

Changes in services provided and changes made by private non-profit and other types of agencies are shown in the following table: [8]

Use and Type of Agency	1975	1976	Percent Increase
	(In Thousands)		
Persons Served			
All agencies	499.6	588.7	17.8
Private non-profit	50.5	103.6	105.1
All others	449.1	485.1	8.0
Visits			
All agencies	10,805	13,335	23.4
Private non-profit	1,656	3,285	98.4
All others	9,149	10,050	9.8
Visit Charges			
All agencies	$211,944	$292,697	38.1
Private non-profit	39,682	85,376	115.2
All others	172,262	207,321	20.4

[8] For detailed data on 1975 utilization, see Wayne Callahan, ibid.

Distribution of Services and Charges by Type of Agency

Visiting nurse associations (VNAs) furnished more home health services than any other type of agency, having provided 4.9 million visists to 245,800 Medicare beneficiaries during 1976. On a per-person-served basis, however, VNAs ranked below the national averages in all measures of utilization and charges. In contrast, proprietary and private non-profit agencies accounted for only approximately 22 percent of the persons served, but they provided 30 percent of the total visits and submitted bills for 35 percent of total charges for visits among all types of agencies. These agencies had the highest average number of visits and average visit charges per person served, well above the national averages. The distribution of visits per person served by selected percentiles is presented by type of agency in Table 8. Because a large number of persons served received relatively few visits, the average number of visits per person, 22.7, is much larger than the median (50th percentile) number of visits per person, 11.6. That is, half of the persons served, 294,000, received 11.6 or fewer visits. Further, 90 percent of the persons served received 56.0 or fewer visits. By type of agency, proprietary, and private non-profit agencies ranked considerably higher in number of visits per person than all other agencies for each of the percentiles shown.

Table 9 shows that the proprietary and private non-profit agencies differed significantly from the other types of agencies in the mix of visits provided. Nursing visits constituted over 60 percent of the visits furnished by home health agencies other than the proprietry or private non-profit agencies while, for the latter, nursing visits constituted only about half or less of the visits furnished. On the other hand, home health aide visits constituted upward of a third of the visits furnished by proprietary and private non-profit agencies while for the others they constituted about a quarter of the visits. The distribution of the charges by type of service parallels the distribution of visits. Charges derived from home health aide visits constituted a significantly greater source of revenues for the proprietary and private non-profit agencies than for the others. Given the greater rate of increase in the number of these agencies, their impact on the change in the mix of services provided to beneficiaries between 1974 and 1976 (noted in Chapter II) becomes manifest.

The distribution of agencies having submitted bills for home health services by type and geographic division is shown in Table 10. Nationally, 50 percent of the agencies were administered by State or local health departments, while visiting nurse associations represented an additional 20 percent of the total.

There were geographic differences by type of agency. VNAs accounted for two-thirds of all home health agencies in New England, as compared to only 1 percent in the East South Central States. In contrast, 78 percent of the agencies in the East South Central States were administered by State or local governments, compared to 19 percent in New England. Private non-profit agencies were concentrated in the South, with 64 percent of them located in the three southern divisions. Also, two-thirds of the agencies located outside of the United States were classified as private non-profit. Proprietary home health agencies must be licensed by the State in order to participate under Medicare, and 13 States had licensure laws in 1976. Two-thirds of the proprietary agencies were located in California and Louisiana.

Table 8
Number of Persons Served, Number of Visits, and Selected Percentiles, by Type of Agency, 1976
(In thousands)

Type of Agency	Persons Served	Visits	Visits per Person	Percentiles (visits)			
				50th	60th	75th	90th
All Agencies	588.7	13,335	22.7	11.6	16.1	27.5	56.0
Visiting Nurse Association	245.8	4,901	19.9	9.7	13.5	23.4	49.5
Combined Government and Voluntary	18.7	317	16.9	7.6	10.7	18.4	42.4
Government	124.0	2,556	20.6	10.4	14.2	24.6	50.8
Hospital Based	63.3	1,318	20.8	11.7	15.8	25.7	49.2
Proprietary	24.5	724	29.6	16.9	23.4	38.2	72.0
Private Nonprofit	103.6	3,285	31.7	19.3	25.8	41.7	76.4
Other	8.8	233	26.4	14.2	20.3	34.7	68.0

Table 9
Percentage Distribution of Visits and Charges by Type of Agency, 1976

Type of Agency	Type of Visits					Visit Charges				
	Total	Nursing	Home Health Aide	Physical Therapy	Other	Total	Nursing	Home Health Aide	Physical Therapy	Other
All Agencies	100.0	59.1	28.3	9.6	3.0	100.0	60.8	24.6	10.8	3.7
VNA's	100.0	62.7	26.1	8.4	2.8	100.0	65.2	22.2	9.0	3.6
Combined Government and Voluntary	100.0	64.4	24.4	8.2	2.8	100.0	72.1	17.1	8.1	2.8
Government	100.0	62.0	27.8	8.1	2.1	100.0	67.3	21.7	8.6	2.3
Hospital Based	100.0	61.5	20.6	13.3	4.6	100.0	60.4	20.2	14.0	5.3
Proprietary	100.0	44.5	40.9	11.0	3.6	100.0	47.7	35.3	12.7	4.3
Private Nonprofit	100.0	52.4	33.5	10.7	3.4	100.0	53.6	29.8	12.5	4.0

Table 10
Number and Percentage Distribution of Home Health Agencies That Submitted Bills for Home Health Services, by Type of Agency and Geographic Division, 1976

Division	All Agencies	Visiting Nurse Association	Combined Govern- and Voluntary	Govern-ment	Hospital Based	Proprie-tary	Private Nonprofit	Other
Total	2,451	498	44	1,218	274	91	277	49
New England	328	218	5	63	24	0	14	4
Middle Atlantic	275	94	5	81	80	0	10	5
East North Central	375	82	11	197	35	7	32	11
West North Central	266	21	6	191	33	0	10	5
South Atlantic	309	25	6	155	21	8	88	6
East South Central	345	4	1	270	27	7	32	4
West South Central	271	13	4	158	9	26	56	5
Mountain	98	8	5	57	12	6	5	5
Pacific	163	32	1	44	30	36	16	4
Other Areas [1]	21	1	0	2	3	1	14	0
Percentage Distribution								
Total	100.0	20.3	1.8	49.7	11.2	3.7	11.3	2.0
New England	100.0	66.5	1.5	19.2	7.3	—	4.3	1.2
Middle Atlantic	100.0	34.2	1.8	29.5	29.1	—	3.6	1.8
East North Central	100.0	21.9	2.9	52.5	9.3	—	8.5	2.9
West North Central	100.0	7.9	2.3	71.8	12.4	—	3.8	1.9
South Atlantic	100.0	8.1	1.9	50.2	6.8	2.6	28.5	1.9
East South Central	100.0	1.2	.3	78.3	7.8	2.0	9.3	1.2
West South Central	100.0	4.8	1.5	58.3	3.3	9.6	20.7	1.8
Mountain	100.0	8.2	5.1	58.2	12.2	6.1	5.1	5.1
Pacific	100.0	19.6	.6	27.0	18.4	22.1	9.8	2.5
Other Areas	100.0	4.8	—	9.5	14.3	4.8	66.7	—

[1] Includes Puerto Rico, Virgin Islands, and Guam.

Conclusions

Home health services under Medicare have been increasing significantly since the Social Security Amendments of 1972 liberalized the home health provisions. This growth trend appears to be continuing, based on preliminary tabulations of bill information received and processed for services in 1977. The basic service of HHAs is a home visit. The number of visits increased by 65 percent between 1974 and 1976 (8.1 million visits and 13.3 million visits, respectively). The main reason for this increase was a sharp rise in the number of persons receiving visits, 392.7 thousand in 1974 to 588.7 thousand in 1976. Preliminary tabulations for 1977 show that an estimated 690 thousand persons received over 15.5 million visits in 1977.

The type as well as the volume of visits is changing. Nursing visits as a percent of total visits decreased from 65 percent in 1974 to 59 percent in 1976. Over the same period, home health aide visits as a percent of total visits increased from 23 percent to 28 percent. This increase in home health aide visits is primarily due to the rapid growth of proprietary and private nonprofit agencies which furnish this type of visit in greater proportion than other types of agencies. Persons using home health aide services as a percent of total persons served increased from 24 percent in 1974 to 31 percent in 1976. Over the same period, the relative number of persons using nursing services remained the same—96 percent.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HOME HEALTH AGENCY REPORT AND BILLING
HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved
Budget Bureau No.
No. 72 - R736

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER

3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)	4. DATE OF BIRTH	5. SEX
		☐ M ☐ F

6. HOME HEALTH AGENCY NAME AND ADDRESS	7. PROVIDER NO.	9. NAME AND ADDRESS OF ATTENDING PHYSICIAN
	8. MEDICAL RECORD NO.	

10. DATE CARE STARTED	11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES	12. VERIFIED DATES OF STAY IN ITEM 11 FROM / TO	13. DATE HOME HEALTH PLAN ESTABLISHED

14. PAYMENT SOURCE FOR CHARGES TO PATIENT

A. ☐ SELF OR FAMILY C. ☐ BLUE CROSS BLUE SHIELD E. ☐ PUBLIC AGENCY (Give name)

B. ☐ PRIVATE INSURANCE D. ☐ EMPLOYER OR UNION F. ☐ OTHER (Explain)

15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)	DATE

16. DIAGNOSES	EMPLOYMENT RELATED	LEAVE BLANK
	A. ☐ YES B. ☐ NO (If yes, give name and address of employer.)	

17. STATEMENT COVERS PERIOD FROM	TO	18. DATE OF FIRST VISIT	DATE OF LAST VISIT	19. PATIENT	20. DATE APPLICABLE TO ITEM 19
				☐ DISCHARGED ☐ STILL RECEIVES SERVICES ☐ DIED ☐ VISITS EXHAUSTED	

21. STATEMENT OF SERVICES RENDERED	POST - HOSPITAL PLAN		MEDICAL PLAN		22. POST - HOSPITAL PLAN	23. MEDICAL PLAN
PRIMARY PURPOSE OF VISIT	NO. VISITS	CHARGES	NO. VISITS	CHARGES	A. TOTAL CHARGES	A. VERIFIED DEDUCTIBLE
A. Skilled Nursing Care		$		$		
B. Physical Therapy					B. REIMBURSEMENT RATE	B. VERIFIED COINSURANCE
C. Speech Therapy						
D. Occupational Therapy						
E. Medical Social Services					C. REIMBURSEMENT AMT. A TIMES B	C. TOTAL CHARGES
F. Home Health Aide						
G. Other Visits (Specify)						D. REIMBURSEMENT RATE
H. Total No. of Units of Service						
I. Charge per unit of Service $						E. C TIMES D
J. TOTALS		$		$		F. E LESS A
K. Other (Specify)						G. REIMBURSEMENT AMT. 80% OF F
						H. REFUND TO PATIENT
L. TOTAL CHARGES		$		$		
M. AMOUNT PAID BY PATIENT				$		I. NET AMOUNT TO AGENCY, G LESS H

I certify that required physician's certification and recertifications are on file.

SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE	DATE FORWARDED	APPROVED BY	DATE APPROVED

Appendix B
Sources and Limitations of Data

Data in this report were obtained from billing forms submitted by home health agencies for Medicare beneficiaries receiving reimbursable services. Data shown are estimates based on a 40 percent sample of the enrolled population and hence are subject to sampling variability. [7]

Data presented in this report for 1976 are based on bills submitted and recorded in SSA through December 1977. The sample counts for 1976 have been inflated to give an estimate of the utilization of home health services as of that date. The file is incomplete to the extent that approximately 2 percent of the bills for 1976 had not been submitted for payment as of December 1977.

Only payments for covered services provided to beneficiaries are reflected in the amounts reimbursed; costs of program administration, deductible, and noncovered services are excluded.

Payments for home health services shown in this report are based on interim rates that are adjusted after the end of the accounting year on the basis of reasonable costs of operation.

Information from the billing forms is matched to SSA's beneficiary enrollment file and to a master provider file which describes the characteristics of each agency.

Appendix C

The tables in Appendix C show approximate standard errors for some of the more important estimates presented in this report. The standard error is primarily a measure of sampling variability, that is, of the variation that occurs by chance, because a sample rather than the whole population is used. In order to calculate the standard errors at a reasonable cost, approximate methods were used. Thus, these tables should be used only as indicators of the order of magnitude of the standard errors for specific estimates.

In general, estimates of small totals, small percentages or means, and percentages or means with small bases or for small subgroups tend to be relatively unreliable. However, because of the large sample used for estimates in this report, very few estimates are likely to have relative standard errors greater than 10 percent.

Table C.1
Approximate Standard Error of Number of Persons Served

Estimated Number of Persons Served	Standard Error of Estimate
1,000	40
10,000	130
50,000	290
100,000	400
200,000	570
400,000	800

Table C.2
Approximate Standard Error of Number of Visits

Estimated Number of Visits	Standard Error of Estimate
5,000	890
10,000	1,300
50,000	3,000
100,000	4,300
500,000	10,000
1,000,000	15,000
4,000,000	31,000
8,000,000	38,000

Table C.3
Approximate Standard Error of Amount of Total Charges, Visit Charges, or Reimbursement

Estimate of Charges	Standard Error of Estimate
$ 50,000	$ 10,000
100,000	14,000
500,000	35,000
1,000,000	53,000
10,000,000	220,000
30,000,000	470,000
100,000,000	710,000
150,000,000	720,000

[7] The reliability of estimates was prepared by James Beebe, Statistical and Research Services Branch, Division of Economic Analysis, Office of Research.

Health Care Financing Program Statistics

U.S. Department of Health, Education, and Welfare
Patricia Roberts Harris, **Secretary**

Health Care Financing Administration
Leonard D. Schaeffer, **Administrator**

Office of Research, Demonstrations, and Statistics
James M. Kaple, **Acting Director**

Diane Bolay, **Director, Program Planning and Support**

Karen Pelham O'Steen, **Research Publications Coordinator**

Send changes of address or requests for this publication to: ORDS Publications, Rm 1E9 Oak Meadows Building, 6340 Security Blvd., Baltimore, MD 21235.